Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: C B. WING IL6014195 09/19/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 150 NORTH WEILAND ROAD SYMPHONY OF BUFFALO GROVE **BUFFALO GROVE, IL 60089** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) DATE CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) S 000 Initial Comments S 000 Complaint Survey Investigaton #1916793 / IL 115765 S9999 Final Observations S9999 Statement of Licensure Violations. 300.1210 a) 300.1210 b)5) 300.1210 c) 300.1210 d)6) 300.3240 a) Section 300.1210 General Requirements for Nursing and Personal Care Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as Attachment A applicable. **Statement of Licensure Violations** b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed

TITLE

(X6) DATE

10/18/19

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  IL6014195			(X2) MULTIPLE CONSTRUCTION  A. BUILDING:  B. WING			(X3) DATE SURVEY COMPLETED	
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NAME OF PROVIDER OR SUPPLIER STREET ADDR				DRESS, CITY, STATE, ZIP CODE			
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BUFFALO GROVE, IL 60089							
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUNDER CROSS-REFERENCED TO THE APPRIOR DEFICIENCY)	ULD BE COMPLETE		
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	each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. Restorative measures shall include, at a minimum, the following procedures:  5) All nursing personnel shall assist and						
	encourage resident transfer activities as effort to help them i practicable level of c) Each direct	s with ambulation and safe soften as necessary in an retain or maintain their highest functioning.  care-giving staff shall review					
	respective resident d) Pursuant to nursing care shall in	subsection (a), general nclude, at a minimum, the practiced on a 24-hour,					
	taken to assure tha remains as free of a All nursing personn see that each resid	ssary precautions shall be t the residents' environment accident hazards as possible. el shall evaluate residents to ent receives adequate sistance to prevent accidents.					
	Section 300.3240	Abuse and Neglect					
		censee, administrator, of a facility shall not abuse or					
	These regulations v	vere not met as evidenced by:					
		and record review the facility sfer a resident. R1 was found					

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they lifted R1 back to bed under arms and did not

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leg. V7 stated he did not have any assistance

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